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IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF SAN FRANCISCO
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PATRICIA HENLEY,)
Plaintiff,)
vs.) No. 995172
PHILIP MORRIS INCORPORATED; et al.,)
Defendants.)
_____)

DEPOSITION OF VICTOR E. GOULD, M.D.
December 5th, 1998

REPORTED BY:
NANCY L. BARKER, CSR #10859, RPR

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DEPOSITION OF VICTOR E. GOULD, M.D.

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BE IT REMEMBERED that, pursuant to Notice of Taking Deposition, and on Saturday, December 5th, 1998, commencing at the hour of 10:20 a.m., at the Law Offices of SHOOK, HARDY & BACON, LLP, One Market Street, Steuart Street Tower, 9th Floor, San Francisco, California 94105, before me, NANCY L. BARKER, duly authorized to administer oaths pursuant to Section 2093(b) of the California Code of Civil Procedure, personally appeared

VICTOR E. GOULD, M.D.

called as a witness by the Plaintiff, and the said witness, being by me first duly sworn, was thereupon examined and testified as hereinafter set forth.

WARTNICK, CHABER, HAROWITZ, SMITH & TIGERMAN, 101 California Street, Suite 2200, San Francisco, California 94111-5802, represented by MADELYN J. CHABER, ESQ., appeared as counsel on behalf of the Plaintiff.

SHOOK, HARDY & BACON, LLP, One Market Street, Steuart Street Tower, 9th Floor, San Francisco, California 94105, represented by GERALD V. BARRON, ESQ., appeared as counsel on behalf of the Defendants.

ALSO PRESENT: Thomas A. Duncan and Patrick Sirridge.

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VICTOR E. GOULD, M.D.,

having been first duly sworn, testified as follows:

EXAMINATION BY MS. CHABER

MS. CHABER: Dr. Gould, my name is Madelyn Chaber and I represent the plaintiff Patricia Henley of this action. I'd like to attach as Plaintiff's first exhibit the Notice of Deposition of Dr. Gould. If you want, I can just write the numbers on the back and we can take time to do it at a break; is that acceptable to everyone?

MR. BARRON: Sure.

(Whereupon, Plaintiff's Exhibit No. 1 was marked for identification.)

MS. CHABER: Q. Dr. Gould, were you provided with a copy of the notice of your deposition?

A. Yes, ma'am.

Q. And did you bring all materials with you called for in that notice?

A. Yes, ma'am.

Q. And in front of me I have what has been

given to me and you've just represented were all the materials that you had pursuant to that notice and the first would be the curriculum vitae and bibliography --

MR. BARRON: Vitae if you want to be Latin.

MS. CHABER: -- of Victor Gould, M.D., and it is 48 pages and I would attach that as a copy that can be used to attach --

MR. BARRON: Sure.

MS. CHABER: -- as next in order Exhibit 2.

(Whereupon, Plaintiff's Exhibit No. 2 was marked for identification.)

MS. CHABER: Q. Is this a current CV, Doctor?

A. It was current at the time I sent it a couple of months ago. There may be one or two more publications since but nothing very dramatic.

Q. Do you know what publications those would be that would not be represented on your CV?

A. They actually are represented but it's probably stated in press as this thing having come out and one of them for sure has come out which is this. The one marked there has come out.

Q. And if you can just read the number that appears before that and the page number?

A. 28.

Q. It's page 38?

A. Page 28.

Q. Excuse me, 28 and the publication?

A. The paper is 209.

Q. Thank you. Could you state your business address for the record, please?

A. Department of Pathology, Rush Medical College, Chicago, Illinois 60612.

Q. And, Dr. Gould, you have been retained as an expert on behalf of Philip Morris in this case Patricia Henley versus Philip Morris.

Have you been deposed before in other cases where people have alleged cigarette-related injuries?

A. Yes, I have.

Q. On how many occasions?

A. I believe twice.

Q. And have you been deposed in any other type of medical-legal case other than those where people are alleging cigarette-related injuries?

A. Yes, I have.

Q. And how many times have you been deposed in other cases?

A. Maybe six or seven.

Q. Are you familiar enough testifying as an expert with the admonitions generally given at the beginning of a deposition being under oath and not guessing and speculating?

A. Admonishment, please.

Q. This deposition is being taken pursuant to the rules of the State of California. Do you understand that; yes?

A. Yes. And if it is not clear, then please explain what those particular rules may be.
Q. I will. I assume that counsel -- you have met with the attorneys representing Philip Morris here today?
A. Yes, I have.
Q. And they have advised you about the procedures in California?
MR. BARRON: I don't think you ought to get into the attorney-client discussions that we've had. You're certainly entitled to find out from him what, if anything, he understands about those rules if you think they are important as a preamble to your question.
MS. CHABER: Q. Dr. Gould, are the attorneys from Shook, Hardy & Bacon your personal attorneys?
A. No, ma'am.
Q. And you are appearing here as an expert

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witness, correct?
A. Yes, ma'am.
Q. And as an expert witness the conversations that you have with counsel regarding your expert testimony in this case are conversations that I may inquire about; do you understand that?
A. I do.
Q. And with respect to the taking of this deposition were you given any information or counseling by the attorneys for Philip Morris regarding procedures for taking depositions in California?
A. Not that I recall. As I said and as you know, I have been deposed before and I don't know to what extent the rules in California may be significantly different from those that I have been given in depositions before.
Q. Where have you been deposed before first in cigarette-related cases?
A. I have been deposed in only two states and that is Illinois, of course, and New Jersey, I believe.
Q. And when were you deposed in Illinois?
A. The last time very recently about a year ago.

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Q. In a cigarette-related case?
A. No, quite unrelated.
Q. The first cases I was asking you about are those in which there were allegations of cigarette-related injuries and you said you had been deposed two times.
A. As a matter of fact, it was in fact in Illinois and it was cigarette-related and I made the mistake because it was done by telephone, so I don't know where the other lawyer was, but I was in Illinois, so I don't know what rules prevail in that case and I was not warned about any particular rules that I did or did not know about.
Q. Where was that case pending; I understand you were in Illinois and the lawyers were somewhere else?
A. The case was pending in Florida.

Q. And do you remember the name of that case?
A. I believe Karbynck.
Q. And did you testify in trial in that case?
A. Yes, I did, ma'am.
Q. And was that in Jacksonville, Florida?
A. It was in Florida. I believe it was

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Jacksonville.
Q. And you indicated that you were also deposed in New Jersey in a cigarette-related case?
A. That's correct.
Q. Were you physically in New Jersey?
A. Yes, I was physically in New Jersey at that time.
Q. And the case was pending in New Jersey?
A. The case was pending in New Jersey, yes.
Q. And do you recall the name of that case?
A. I do and that was Ed Chippolone.
Q. And did you testify in trial in the Chippolone case?
A. Yes, I did.
Q. And can you give me the approximate year of that case?
A. Yes, that was in '88.
Q. And Karbynck?
A. That was in '97.
Q. And the six to seven times that you testified in other types of medical-legal cases, when was the first one that you testified in?
A. The first time probably goes back to '76. It's a long time ago in the '70s.
Q. And where was that case pending?

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A. Again, the case originated from Alaska as a matter of fact and I don't know where the case was eventually settled and it had nothing to do with tobacco.
Q. I understand.
A. But I was deposed in Illinois. I don't remember where the case had been filed but the patient was from Alaska, that I do remember. I had seen the case in consultation.
Q. And what type of a case was it?
A. It was a questionable lesion of the breast benign versus malignant.
Q. And was the nature of the action a malpractice case?
A. Yes.
Q. And did you testify on behalf of the individuals suing or on behalf of the doctor being sued?
A. No, on behalf of the doctor being sued.
Q. And you indicated that case was settled so there was no trial for you to testify at?
A. That's correct. It never came to trial.
Q. And what was the next medical-legal case that you were involved in? Again, we are talking about other than the two we've discussed.

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A. Years went by and you'll have to forgive me I don't remember exactly, but there was one case,

again, all of these except one -- except two. One of them was again a question of diagnosis of a particular type of lung tumor versus another that would have altered the treatment and so on and so forth.

Q. Were all six or seven of these cases that you were deposed in that were noncigarette-related medical malpractice cases?

A. No. As a matter of fact, not exactly, although there was an element of that involved as you will see. That one of the carcinoma of the lung was one of them that was straight malpractice.

There was another one of a tumor that metastasized to the liver; and, again, the question was whether it was one thing or another, the primary or a metastasis. Then there were two cases in which one of them was a patient and in that case I was deposed and gave testimony.

Q. As a treating doctor?

A. Yes, as an expert witness on behalf of the plaintiff as a matter of fact.

Q. Let me just stop you there. Were those medical malpractice cases or some other nature?

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A. The one that I was about to tell you was not straight medical malpractice, no. It was a fellow that had a pleural tumor that I believe was a mesothelioma and there was a question of asbestos exposure and that defense whoever they were argued that it was not a mesothelioma and I was in that instance on behalf of the patient as it were.

And then there was another case that I gave a deposition and that also eventually went to court of an infant and all of this was pro bono by the way, an infant that had very low blood sugar. I'm being slow because I'm trying to make it readily understandable.

Q. To recall?

A. No, I recall the case very well because I eventually published that case. An infant that presented in the emergency room with convulsions and very low blood sugar and that led to initially partial resection of the pancreas and subsequently did a complete resection of the pancreas because the low blood sugar did not seem to be changed by the treatment.

And the State of Illinois that brought the case in fact brought the case against the mother because it was felt that the mother in fact was

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administering insulin to the infant and that was proven to be the case.

Q. What's the syndrome called, what you were testifying about?

A. Yes, it was -- the syndrome itself is called --

Q. Munchausen?

A. -- Munchausen, M-u-n-c-h-a-u-s-e-n apostrophe s, by proxy because the Munchausen is when you do it to yourself or individually itself and in this case it was a third individual that happened to be the mother of this infant so that case came to court as well.

Q. In that case you were testifying on behalf of the State of Illinois?
A. The State of Illinois that was attempting to take custody of the infant.
Q. And you said you published that case?
A. It's in press. I don't know if it's included because I don't know if it had been accepted by the time that I submitted this because I was not able to submit the paper for publication until all the legal things had been cleared up.
Q. And in that case you were involved in the actual medical treatment --

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A. Not at all. I was called in as a consultant in the case because if you examine my curriculum, I have written on that condition itself among other things, and so the endocrinologist that was -- that reached the conclusion -- the dramatic conclusion that I told you about and eventually furnished proof of that suggested that I be an expert witness to indicate what the facts were as they were.
Q. And on the case where you testified that it was a mesothelioma in this individual and you were testifying on his behalf, did that go to trial?
A. Yes, it did.
Q. And where was that case pending?
A. In Illinois, in Cook County.
Q. And do you know who the plaintiff's attorney was in that case?
A. No, I don't remember.
Q. Do you remember the name of that case?
A. Yes, I remember the name of the patient because he was, as a matter of fact, still alive and at the trial. The name of the patient, if my memory serves me well, was Overbeck. That was a number of years ago.
Q. Do you recall -- can you give us an

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approximate date?
A. Eight, ten years ago, maybe a bit less.
Q. I think that brings us up to about to three out of the six or seven cases that were noncigarette-related. Can you recall what the other two or three were?
A. Frankly, I don't and I have destroyed those files. They were very long ago and I destroyed those things long ago.
Q. Do you recall whether or not they were the nature of any of the actions, malpractice?
A. Yes, there was an element of malpractice. I remember that one, as a matter of fact, was a thymoma, as a matter of fact, now that you asked me again, and that's about all I remember at the moment.
Q. And do you recall on whose behalf you were testifying, plaintiff or defendant?
A. I think the patient.
Q. Now, Dr. Gould, you understand that this deposition is under oath and it's the same oath as you would be given in a court of law?
A. I do.
Q. And I would ask you that if a question is

asked of you for which your answer would be a guess,
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that you not guess at your answer; will you remember to keep that admonition?
A. I will try. And if by habit I do otherwise, please remind me.
Q. I am entitled, though, to your best estimate or your best recollection short of you guessing on something and I would ask you to provide that in those instances where you cannot recall exactly the response to an answer; will you keep that in mind?
A. I will try, ma'am.
Q. And I think we've been doing fairly well up until now allowing each other to finish our questions or answers so that the court reporter can take down the testimony and have a nice clean record and I'll try, if you will, sir, to keep that up?
A. Quite so.
Q. Now, the other piece of material that I've been given that you brought in as part of your file were a document entitled, "Plaintiff's Disclosure of Expert Witnesses"; did you review that document, sir?
A. Yes, I looked at it.
Q. And does that enter in any way in the opinions that you are going to express today?
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A. No, ma'am.
Q. Do you know why you were given that document?
A. I frankly don't.
Q. Did you have any discussions with anyone on behalf of Philip Morris about that document?
A. No.
Q. Also you were provided the report from Dr. Samuel Hammar a pathology report; did you review that report?
A. Yes, I did.
Q. Do you know Dr. Hammar?
A. Yes, I do.
Q. And do you have an opinion as to Dr. Hammar's expertise as a pathologist?
A. I think he's a very competent fellow.
Q. You were given a September 23rd, 1998 report of a Dr. Barry R. Horn regarding Patricia Henley. Did you review that report?
A. I looked at it very quickly.
Q. And does it in any way -- do you rely or have you reviewed it in any way with respect to the opinions you formed in this case?
A. No.
Q. Is there a reason why you did not review
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a report of the doctor who saw the patient?
A. I believe I read the medical records including the summaries. I don't know to what extent those may be yet another summary of the very summaries that I already read, moreover I was given that particular document that you have in your hand just yesterday, so it wasn't very much time.
Q. And you did not review the portions of Dr. Horn's report where he examined Ms. Henley?

A. As I said, I did review very thoroughly the medical records in the bigger file but I did not have the time to go as thoroughly through these.
Q. Is it fair to say, then, that you do not recall reviewing Dr. Horn's physical examination of Patricia Henley if it is not contained within the bigger medical records?
A. That's correct. I looked at them very quickly. I did not review them critically.
Q. And would that be true as well for the pulmonary function tests done at Dr. Horn's laboratory if it is not contained within the larger binder of medical records?
A. No. Again, the thorough review is of the bigger file, not the smaller one.
Q. And if it is not contained within the

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bigger file of medical records, would it be fair to say that you did not review Dr. Horn's review of chest x-rays?
A. Well, you realize as a pathologist I concentrate on the pathology and those additional data are significant as they may be would not be the primary item of which I will focus which is why when you asked me if I had reviewed what Hammar wrote, yes, I did, because that is where I would focus on mainly the pathology.
Q. In answer to my question, is it fair to say, then, that if Dr. Horn's review of chest x-rays and CT scans were not contained within the larger medical file that you've provided, you would not have reviewed it?
A. Not thoroughly, no.
Q. And that would be true as well for x-rays taken at the facility where Dr. Horn practiced if it is not contained within the larger medical files?
A. Well, the significant x-rays, of course, were taken prior to the treatment, in fact, are included in the main file.
Q. So in answer to my question then, is it fair to say that if the x-ray report, the x-ray taken at Dr. Horn's facility was not included within

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the medical file, the larger record that I'll attach as an exhibit, you would not have reviewed it or you did not review it?
A. That's correct, not thoroughly and I would not be prepared to discuss that.
Q. And did you review actual chest films or CT scans yourself?
A. No. I did see them but I rely -- I don't consider myself an expert radiologist, and I rely on the report of the radiologist.
Q. Did you ask to see the actual physical chest x-rays and CT scans in order to prepare for either your opinions or your testimony here today?
A. Well, the x-rays and the CAT scans were also, as you know, reviewed by Dr. Warren and I was present during one of those reviews.
Q. And who else was present during the review that you were present with with Dr. Warren?
A. Mr. Sirridge.
Q. And did you and Dr. Warren have any

additional conversations, discussions about the Patricia Henley matter other than on that one occasion when you were present with him and a Philip Morris attorney?

A. Not beyond that meeting.

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Q. And am I correct that Dr. Warren and you have been co-authors on numerous publications and articles?

A. That is a matter of record. It's included in my CV, of course.

Q. So the answer is yes?

A. Absolutely, it's a matter of record. It's in my CV.

Q. I understand certain things. I'm trying to get a nice clean record. So is it true and correct that you and Dr. Warren have published numerous publications and papers together?

A. Immaculately true.

Q. Thank you. And how long was this review of x-rays and CT scans by Dr. Warren in your presence?

A. An hour plus maybe.

Q. And when did this occur?

A. A couple of months ago maybe.

Q. Have you reviewed with or discussed with anyone a further review of subsequent x-rays or CT scans subsequent to that meeting?

A. Not that I can recall, no.

Q. And were there any notes made by you or Dr. Warren in your presence regarding the review of

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the x-rays and CT scans at the meeting that you were at?

A. I made no notes.

Q. Is that your general practice when you are dealing with an area of a patient -- strike that. I'll get to that later.

Let me get an idea of the time you spend doing various of your activities. Can you give me first a list of the types of activities that you engage in professionally? I don't care if you ski or something like that. I'm talking about your professional activities.

A. You mean normally at work?

Q. I'm trying to get a sense. You do some research, correct?

A. That's correct.

Q. What other things do you do besides research?

A. Conventional diagnostic pathology which is the bulk of what I do.

Q. And that is a hospital base practice?

A. That's correct.

Q. Do you teach?

A. Yes, I do.

Q. And is the teaching part and parcel of

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your review of conventional diagnostic pathology or is that a separate activity?

A. There are three components to that: One is what you would call part and parcel, the apprenticeship, in other words, when we are looking

at real life cases every day with residents, that is, then there is lecturing and laboratory sessions for medical students.

And then there is -- there are the conferences, interdisciplinary conferences with other departments within the institution and, of course, the fourth heaven is the lecturing that I often give outside of our medical center.

Q. And in addition to the research, the conventional diagnostic pathology, your teaching as you've just described, you also --

A. The administrative problems, personnels, related schedules, that kind of thing.

Q. And do you consult on medical-legal cases?

A. You have the extent of that consultation.

Q. The earlier question I had asked you related specifically to depositions and/or testimony. Are there occasions that you consult on legal cases where it may not result in a deposition

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or trial testimony?

A. Rarely there have been instances of that, yes. In other words, I would have been shown a case and I have no idea what happened to it subsequently.

Q. And you are asked to come to a deposition or a trial?

A. Correct.

Q. It was not something that you followed?

A. Correct.

Q. And can you give me any kind of estimate of the number of times that that occurred?

A. Occasionally, rarely. I couldn't give you -- it would be a guess.

Q. Over the last ten years is there any way for you to approximate the number; is it more than five, less than ten, that type of an approximation?

A. I don't know because occasionally or not infrequently I would be consulted by other pathologists in the local area and would not be told the reason for the consultation and I simply handled the case as if it were outside.

In other words, if it was entered in the departmental log as an OS, outside slides, diagnose, bill accordingly and that's all there is to it. So I couldn't give you a real estimate. I have no idea

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whether there are medical-legal questions underneath the number of them.

Q. And have we pretty much covered the activities that you were involved with professionally?

A. Those that you asked me that you wanted to hear about, yes.

Q. I'm asking you if there are any others?

A. Professionally related, no.

Q. Right. I don't want to know your personal activities, correct.

A. Right.

Q. Can you give me a breakdown of the percentage of your time that you spend on each of these? I'm happy to go through them in the order that you gave them to me or we can go in any order

that you wish at your presence.
A. That is a little bit more difficult than you might be willing to believe.
Q. You are going to tell me it adds up to more than a hundred percent?
A. No. What I will tell you -- not even I can go beyond a hundred percent. The difficulty lies in that some of these activities are intertwined; in other words, the teaching of the
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residents goes together with my actual diagnostic work in signing out of the cases, and so those two activities are so intertwined that it's very difficult to separate.
Q. Okay. If you want to lump them together --
A. If you put that together, that probably takes, I would say, two-thirds of my time and with most of the rest -- most of the rest will be taken by research and the rest of the teaching activities.
Q. And as between the research and the remainder of the teaching activities?
A. The bulk will go for the research, of course.
Q. Now, you indicated that certain cases you worked on -- when I say cases, I'm talking about legal cases. You worked on pro bono I think was the --
A. One of them that case of that infant that I discussed with some detail.
Q. And I assume that this case doesn't fall into the pro bono category today?
A. It's not within that definition.
Q. I had a feeling and I was advised and I hope this is correct -- and you can tell me if it's
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not -- that for deposition testimony you charge $500 an hour?
A. That's correct.
Q. We are about one hour into it. I will give you a check for a thousand dollars which would represent two hours. If we go over, I have an additional check and beyond that I would ask you either to advise counsel or bill me because my own personal bank checks would bounce. That's all I have with me.
Please, one of the admonitions I normally would give is obviously if you need to take a break at any point in time, I'm happy to stop and likewise if counsel needs a break; otherwise, I'd like to go about an hour and a half.
The court reporter -- if that's acceptable to the court reporter. She's nodding her head, and then give her a little bit of break since she's doing all the work here. But by all means if you want to break earlier than that, we can.
When were you first contacted in the Patricia Henley matter?
A. Late summer, early fall. I don't recall the exact date.
Q. Do you have any transmittal letters or
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memos to or from the people who contacted you?

MR. BARRON: We have one here for you.
MS. CHABER: Okay. I've just been handed an October 21st, 1998 letter to Dr. Gould from a Jane Ascheman from the Shook, Hardy office here in San Francisco transmitting medical records of Patricia Henley.
Q. Does this letter refresh your recollection at all when you were first contacted?
A. This is what accompanied these records so it was subsequent to my having heard the case which is why I told you late summer or early fall.
Q. So the October 23rd --
A. I have destroyed the original of this letter. I just kept the file.
Q. The October 23rd report which we will mark as Plaintiff's Exhibit 3 I think we are up to and we will mark what you keep pointing at and what I keep referring to which is a black binder entitled, "Patricia Ann Henley, Henley versus Philip Morris, et al., Complete Medical Records" as plaintiff's next in order Exhibit 4.
(Whereupon, Plaintiff's Exhibit Nos. 3 and 4 were marked for identification.)
MS. CHABER: And let me ask you some

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questions about that first, Doctor.
Q. This binder Plaintiff's Exhibit 4 you believe was what was sent in conjunction with the transmittal letter of October 23rd?
A. It's the only material I received so it must be.
Q. Okay. And prior to that October 23rd case were you given any information whether verbally or in any other form about the Patricia Henley case?
A. Well, prior to that I had seen -- I had been shown the slides of the case and it was after that that the records were sent.
Q. When were you shown the slides of the case?
A. As I just told you, it must have been prior to that. That's why I said late summer, early fall.
Q. Can you give me an idea how much prior to October 23rd, a week, a month?
A. It would have been a month before, maybe September.
Q. And how were those slides provided to you, were they mailed, were they delivered, were they accompanied by a lawyer?
A. No, that was part of that meeting with

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Mr. Sirridge who brought the slides. That was part of the meeting that I referred to before.
Q. And was Dr. Warren present in the portion of the meeting where you were shown the slides?
A. That I cannot recall because he is a very busy fellow and he might have been coming in and out at that time so I don't know if he was physically present when I was in fact looking at the slides.
Q. And with respect to the meeting regarding the slides, Mr. Sirridge was present, you were present, Dr. Warren may or may not have been in and out of that meeting?

A. You understand that he's probably being paged and that kind of thing.
Q. Was there anyone else present?
A. Not that I recall.
Q. And where did this meeting take place?
A. In an office in my lab.
Q. And did you physically review the slides at that meeting?
A. Yes, I did.
Q. And did you review the slides and then show Mr. Sirridge things within the slides?
A. Mr. Sirridge was in fact looking at the slides as I was looking at them with one of those

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double-headed microscopes.
Q. And as you looked at the slides, were you describing for Mr. Sirridge what you had seen?
A. Yes, I was examining the case the way that I would do when one of our residents or somebody from another department would show me an unknown case and so Mr. Sirridge was posing I guess as a resident at the time.
Q. Do you know if Mr. Sirridge has any medical training or background?
A. I don't know that he has any official medical training.
Q. Do you know that he has any unofficial medical training?
A. Well, he has certainly looked at slides and read a great deal about medicine.
Q. And how do you know that he certainly looked at slides?
A. I'm sorry?
Q. How do you know he has certainly looked at slides?
A. Because we have looked at a couple of other cases together as well.
Q. Okay. And what other cases were those that you looked at together?

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A. Well, one of those cases was the Chippolone case.
Q. And that was Mr. Sirridge; was anyone else present when you reviewed slides on the Chippolone case?
A. That was close to 14 years ago. Now, you are really asking me to stretch that.
Q. Even if you don't know names, do you recall there being other people present at the time that you reviewed slides in the Chippolone case with Mr. Sirridge?
A. No, I don't remember.
Q. And did you likewise review slides in the Karbynck case with Mr. Sirridge?
A. No. Mr. Sirridge was not involved in that case.
Q. Did you review slides with another attorney?
A. Well, one of the attorneys involved was Mr. Duncan. The other fellow's name I really don't recall.
Q. Do you know if the other fellow with whom you reviewed slides on the Karbynck case was someone

from the Shook, Hardy law firm?
A. No, he was from another firm, that I do
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know.
Q. And did he represent as far as you are aware a different cigarette manufacturer?
A. Yes, he did.
Q. And do you know what cigarette manufacturer he represented?
A. If my memory serves me correctly, it was Reynolds, if I remember correctly.
Q. During -- is that the only time that you have reviewed the slides in this case the meeting that you described with Mr. Sirridge?
A. No. He left the slides with me and I looked at them in more detail the following day on my own before they were picked up.
Q. At the meeting reviewing the slides with Mr. Sirridge, did you take any notes of what you were seeing on the slides?
A. No, ma'am.
Q. And when you reviewed the slides in more detail the following day, did you make any notes of what you were seeing?
A. No.
Q. Did you do any additional tests or preparations on the slides other than what had already been done today?
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A. No, ma'am, I returned them as I received them.
Q. You did no immunohistochemical staining?
A. Absolutely not.
Q. Did you receive any block?
A. No, ma'am, I did not.
Q. Did you request any block in order to make your own slides?
A. No, I did not.
Q. Did you make any request to do any additional testing other than your review of these slides?
A. No, ma'am, I did not.
Q. And did you rereview those slides prior to this deposition and since the time we just described where you reviewed them in more detail?
A. I remember that first time very well. We met once more and discussed the case. I do not recall if I looked at the slides yet again during our second meeting.
Q. And when did that second meeting take place?
A. Oh, somewhere between October and now.
Q. Now here in December?
A. It must have been in October because I
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was in -- it must have been October because I was, in fact, traveling much of November.
Q. And you have not reviewed the pathology since that time of the second meeting which probably occurred in October; is that correct?
A. That's correct.
Q. And I take it you did not write any type of report or dictate any memorandum, notes,

information regarding your review of the slides?
A. No, ma'am, I did not.
Q. Okay. Other than through meetings with the attorneys for Philip Morris in this case and the meeting that you described where Dr. Warren was there as well as an attorney for Philip Morris, have you had telephone conversations or any other form of communications regarding this case at any point since you were first contacted?
A. Not beyond what was required to arrange for this deposition today.
Q. Did you receive any other communications, letters or materials from the attorneys representing Philip Morris in this case other than the one transmittal letter that we've attached as an exhibit?
A. No, ma'am, I did not.

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Q. When did you first form your opinion or opinions regarding the Henley matter?
A. After our first meeting.
Q. In that first meeting are we referring to the first review of the slides, the pathology slides?
A. That's correct, and the x-rays by Dr. Warren, of course.
Q. Was that the same day?
A. Yes. As I told you, I was there when he was reviewing the x-rays, that I know for a fact. I don't recall if he was there while I was looking at the slides.
Q. Which occurred first, the review of the pathology or the review of the x-rays?
A. The slides were first.
Q. And what opinion or opinions have you formed about this case?
MR. BARRON: I'm going to object that it calls for a narrative but obviously he should give you an overview of some of those views. They obviously have components to them.
MS. CHABER: What I'm looking for is an overview so we can then discuss them point by point.
MR. BARRON: I want to make clear we are

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looking at the overview.
MS. CHABER: I don't want the rest of the deposition to be Dr. Gould only talking and me never asking a question. It would be a little hard to deal with.
MR. BARRON: So we have the same desires so with that understanding go ahead and answer.
MS. CHABER: Q. We've said a lot of things that have no effect on the question that I asked you.
A. Would you please ask your question again?
Q. Yes. Dr. Gould, can you tell me what opinion or opinions you have formed with respect to the Henley case?
A. Well, I looked at the slides which contain a few fragments of fibroconnective and fatty tissue that are infiltrated by small malignant cells and I saw an immunostain for a cytokeratin that was positive. I saw one for CD45 that was negative.

Q. CD?
A. CD45 that was negative and one for chromogranin that was negative and one for synaptophysin that was positive.
Q. Can you spell that one?
A. Yes, I can. I designed the work, ma'am,

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s-y-n-a-p-t-o-s-i-n (sic).
Q. And you said that was negative?
A. No, that was positive.
Q. Anything else?
A. No. Those were the materials that I reviewed. And so based on what I saw and the positivity of cytokeratin and the positivity for synaptophysin, I conclude that it was a small cell neuroendocrine carcinoma infiltrating fibroconnective and fatty tissue.
Q. That was fibroconnective and fatty?
A. Yes.
Q. Any other opinions?
A. Well, that was one element and the other element, the other key component in my views pertaining to the case pertain to the x-rays and for that, of course, I rely on the radiologists that stated that this was a mediastinal mass, left upper mediastinal mass that embraced the left pulmonary artery in the absence of pulmonary lesions.
That was another key element in my opinion and the fact that the endoscopic bronchial examination was thoroughly negative and was also a cytology that was negative.
Q. So your opinion is that it in terms --

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A. So the conclusion of putting all those elements together is that Mrs. Henley did indeed have a small cell neuroendocrine carcinoma in the mediastinum but that it did not originate from the lung.
Q. And the conclusion that you reached did you reach any conclusions with respect to the etiology of the small cell neuroendocrine carcinoma of the mediastinum that you diagnosed?
A. Etiology you said?
Q. Etiology.
A. No, I did not.
Q. What causes small cell carcinoma of the mediastinum?
A. I honestly don't know. There are a number, several varieties of them, and I have no idea what may cause them.
Q. Are there any potential causes that you would consider in a list of potential causes of mediastinal small cell neuroendocrine carcinoma?
A. No, I really don't know.
Q. Do you know whether or not cigarette smoking is a cause or contributing factor in small cell neuroendocrine carcinoma of the mediastinum?
A. No, I don't.

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Q. Have you concluded in any way in your work, your research or your opinions that you are rendering today that cigarette smoking is not a causative or contributory cause to small cell

neuroendocrine carcinoma of the mediastinum?
A. No, I have not.
Q. Do you believe that cigarette smoking causes any form of small cell -- strike that. Let me start over. Do you believe that cigarette smoking can cause small cell neuroendocrine carcinomas?
A. I am aware of the fact that it has been statistically linked to some neuroendocrine carcinomas but as you know etiology is not the focus of my work.
Q. Have you at all in any of the research you've done, teaching you've done or in your clinical practice had occasion to conclude what's the etiology of a small cell neuroendocrine carcinoma of a patient for want of a better term?
A. No, I don't.
Q. Is it fair to say, then, that when you are asked to render your opinions with respect to a patient -- and if there's a better terminology for it, please help me with it -- patients that you are

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seeing either through your teaching practice, your clinical practice or your research work -- and I realize some of this is going to be on decedents -- are you ever asked to render an opinion with respect to what is the cause of what you are pathologically diagnosing?
A. Occasionally there is such an instance, yes. Occasionally there are instances. I could give you an example if you like.
Q. I would appreciate that.
A. For instance, there are some tumors that are well-known to be induced by radiation and by therapeutic radiation, that is, that have been, of course, reproduced experimentally and are very well documented to be such.
So we either on autopsy or on surgical, we would issue a diagnosis saying sarcoma, etc., etc., inside of previous radiation such as it may have, in fact, an etiologic significance but that is not the result of my work. I mean, that is a well-established scientific fact.
Q. In the case that you testified with respect to the individual's mesothelioma versus what was the alternative diagnosis that was being offered by the defense in that case?

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A. The defense I believe was alleging that it was a metastatic adenocarcinoma to the pleura which is a classical differential diagnosis.
Q. Was a pseudo mesotheliomatous carcinoma is that the same thing?
A. No. But there are some mesotheliomas that have glands that look very much like adenocarcinoma so they have been traditionally a problematic differential diagnosis.
Q. And that case where you were asked to be an expert on behalf of the plaintiff and you indicated that your opinion was that he had mesothelioma and not this pleural metastasis, did you render any opinion as to what caused his mesothelioma?

A. No. My testimony was limited to the diagnosis of the case which I believe to be mesothelioma.
Q. And in your opinion is a mesothelioma -- was the mesothelioma that you saw in that case caused by the man's asbestos exposure?
A. That was what the plaintiff's lawyer were alleging but I repeat my testimony was limited to the diagnosis of the case.
Q. I understand that your testimony was

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limited. I'm asking you if you formed an opinion with respect to what caused that gentleman's mesothelioma?
A. No, I frankly did not.
Q. Okay. And do you believe that there are other causes of mesothelioma in humans besides asbestos exposure?
A. I would be surprised if there aren't since mesotheliomas clearly existed before asbestos came into widespread use.
Q. Do you believe that asbestos is a cause of mesothelioma?
A. In the case of asbestos there is considerable experimental work that have in fact reproduced the lesion and it varies, of course, with the various forms of the mineral, that I do know; but, again, I have not looked at that matter in depth at any time.
Q. And have you looked at the matter of whether cigarette smoking over a repeated length of time causes any disease in human beings?
A. No, I have not.
Q. And that is not something to which your research, practice or interest is devoted?
A. No. My research work for well over 30

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years which you can see reflected in my publications has been consistently focused on fine-tuning diagnostic tools.
Q. Let me just ask you about this and then we will take a short break. It's 11:30. I have before me a letter dated December 3rd, 1998, on my law office stationery with what looked like some internal routing slips and attached to that are some additional medical records from Imaging Science Center and Consultants for Lung Disease.
First of all, Doctor, have you seen these materials that I've just described to you before?
A. Yes, I have.
Q. And the first time you saw that was when?
A. Yesterday.
Q. Would what was contained within those materials in any way change or affect your opinion?
A. No, they did not because in fact they are isolated and selected copies of the material present in the big black folder that you have in front of you.
Q. So what was provided to you as a separate set of records consisting of some 34 pages you believe are duplicative of what is already contained --

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A. Selected.
Q. -- within the medical binder but not as complete?
A. That's correct.
Q. And was there any new or additional information that you believe was contained within these additional records?
A. Not to my knowledge.
Q. And I'll have that attached as the next in order. If that wasn't clear, I was marking the binder that is designated Patricia Ann Henley, Henley versus Philip Morris, et al., complete medical records as the plaintiff's next in order. So that would be four. And then the additional records would be five.
(Whereupon, Plaintiff's Exhibit No. 5 was marked for identification.)
MS. CHABER: Q. And before we take our break, Doctor, there are some Post-its on some of the medical records within the black binder Exhibit 4.
A. Yes.
Q. Are those Post-its that you placed there or that were placed there by others?
A. Myself.

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Q. And there is two pages that are folded down that represent a January 26th, 1998, report of Dr. Giovanni Smith. Did you do the folding down?
A. Yes, I did.
Q. Was this for the purposes so that you could find --
A. Going back to that, the purpose was to go back to them because at the moment I was out of those yellow self-adhesive things.
Q. And this is a nice neat little binder with the little tabs and everything; I take it that's how the records were provided to you?
A. That is how it arrived.
Q. That isn't what -- you didn't get the records and then put in the table of contents?
A. No.
Q. Okay. With respect to Plaintiff's Exhibit 5 the 34 pages of additional records, likewise, there are Post-its on some of those pages. Did you place those Post-its there?
A. Yes, I did.
Q. And at the time that you placed the Post-its there was it for the purpose of being able to go back to those pages?
A. Uh-huh, yes.

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Q. Another admonition that I left out we must speak in words and not nods of the head because the court reporter can't take that down.
A. Yes.
MS. CHABER: Okay. Let's take a break.
(Break from 11:37 a.m. to 11:51 a.m.)
MS. CHABER: Dr. Gould, we are back on the record again.
Q. You understand the oath continues throughout the deposition?
A. Understood.

Q. Did you have any discussions with any of the lawyers during the break regarding this case or any of the testimony you've given so far?
A. No, ma'am.
MS. CHABER: Off the record.
(Off the record)
(Mr. Sirridge exited proceedings)
MS. CHABER: Q. Doctor, were you given any updated report of Dr. Barry R. Horn?
A. Not beyond what you have.
Q. Okay. Do you recall what the last -- latest date of any chest film or CT scan that has been reviewed with you for which you've read about what it was?

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(Mr. Sirridge re-entered proceedings)
THE WITNESS: No, I don't.
MS. CHABER: Q. Do you believe that there is anything that might change your opinion about the origin of this small cell neuroendocrine carcinoma that could be provided by subsequent CT scanning or x-ray subsequent to the dates that you've seen?
A. Not to my knowledge.
Q. If there were a mass density present now in the upper lung fields, would that in any way impact the opinions you've already rendered?
MR. BARRON: In aid of allowing him to give you his best answer, are you tying this into a report of that in a diagnostic study?
MS. CHABER: I'm asking it as a hypothetical.
Q. Let's assume that there have been recent CT scanning of Ms. Henley and let's assume that the recent CT scanning -- by recent I mean late October -- demonstrated a mass density in the left upper lung field medially and anteriorly adjacent to the ark -- arch of the aorta with stranding extending to the pleural surface anteriorly, would that in any way have any impact upon the opinions

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you've already rendered?
A. I would have to look at that information. I cannot really address myself to a hypothetical question in the terms that you outlined.
Q. What is -- what about the terms that I've outlined do you not understand? And I'll try to clarify.
A. For one reason you said October, right?
Q. Yes.
A. So that is several months after she received the chemotherapy and radiation therapy to the area which may also -- which are both known to be associated with pulmonary lesions. So, first of all, one would have to determine what those pulmonary infiltrates in fact reflect.
We cannot certainly not now after treatment deduct the presence of an infiltrate as you said would necessarily be tumor. And even if it were, since the time sequence is subsequent to the original mass, you would still have to demonstrate what kind of a tumor it is.
It isn't the same and which came first.

Clearly the one in the lung has come second, so you could readily conclude that it represents a metastasis from the primary mediastinum even if it
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were a tumor what you see in the lung.
Q. Could you also conclude that the radiation was effective in at least temporarily resolving a small cell neuroendocrine tumor and has recurred?
A. Radiation will have been, of course, applied to both sides so the argument would still be left open as to which came first.
Q. Let me ask you this: What is your definition of a mediastinal small cell neuroendocrine carcinoma?
A. The definition is one of cell type. In other words, the words that you just used define the tumor. It's a small cell epithelial cancer that expresses neuroendocrine differentiation as indicated in this case by the positivity for synaptophysin that is present in the mediastinum.
Q. How do you know that -- were you able to review slides that clearly were tissue from the mediastinum?
A. The biopsy obtained by mediastinoscopy is indeed from the mediastinum and what was obtained was fibroconnective and fatty tissue which is what I told you would be expected to be obtained and the rest was tumor.
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Q. And it is true, is it not, that small cell -- can we just sort of abbreviate this as small cell rather than saying small cell neuroendocrine carcinoma each time?
A. For the purposes of this case?
Q. For the purposes of this case.
A. I would. If you were one of my graduates, I would not because clearly there are a number of other small cell carcinomas.
Q. For the purpose of this case irrespective of the site of the origin of this tumor, would you agree that all of the physicians whose records you have reviewed have agreed with the diagnosis of a small cell neuroendocrine carcinoma?
A. That is what they have concluded.
Q. Okay. So there is no dispute in your mind then over the cell type, correct?
A. None.
Q. Okay. And the dispute you would agree then is over the location of the origin of this cancer?
A. That is correct.
Q. Okay.
MR. BARRON: I was going to insert what caught my attention with his note. I'm going to
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object to the word dispute as being ambiguous.
MS. CHABER: Let me define dispute.
Q. Doctor, are you aware of any other physician whose records you have reviewed that has concluded that Ms. Henley is suffering from a small cell neuroendocrine carcinoma that originated in the mediastinum?

A. Well, the report of the original pathologist clearly states fragments of fibroconnective tissue with small cell carcinoma and it doesn't mention the lung.
Q. Does it reach a conclusion that it is mediastinal tissue?
A. The question is clearly left open.
Q. Other than that report that you've just described, is there any report, record that you have seen which indicates that there is any physician involved in Ms. Henley's treatment and care who has concluded that Ms. Henley is suffering from a small cell carcinoma of the mediastinum?
A. No, I don't recall that.
Q. And is it fair to say that the physicians who have made a conclusion as to what the origin of Ms. Henley's small cell carcinoma has been to the extent that they have made a conclusion that she is

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suffering from a small cell carcinoma of the lung?
A. That's what they have concluded.
Q. Correct, that's what I'm trying -- counsel here objected to my use of the word dispute so now I'm trying to define where we are at.
Would you agree that as between you and any of the physicians who have treated Ms. Henley who have made a conclusion as to what her diagnosis is that the differential is you say it is a small cell carcinoma of the mediastinum, and they have concluded that it is a small cell carcinoma of the lung?
A. I repeat there is total agreement about the existence of the tumor and about the typing of the tumor. This agreement is at the primary site of it.
Q. And other than the one pathology report you cited me to that did not reach a conclusion with respect to the site of the tumor at least none that's stated there, can you cite me to any record or doctor who has concluded that Ms. Henley the site of origin of her small cell cancer is the mediastinum other than yourself?
A. I can refer to you to all of those records in which the endoscopy very thoroughly

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performed and very thoroughly described specifically states that there is no endobronchial lesion so much so that no site worth biopsing was seen and no biopsy was taken and then again the radiology reports by those very physicians who described very clearly a mediastinal mass and state that the pulmonary field is not involved.
Q. Do any of those reports that you have just cited me to -- and I will ask you in a few moments to define the specific ones that you are referring to -- concluded that Ms. Henley is suffering from a small cell cancer of the mediastinum?
A. No, they have not.
Q. And based on those same reports that you have just referred to, is it fair to say that Ms. Henley's treating physician has been treating her for what he has stated to be a small cell

carcinoma of the lung?
A. Not exactly. She was treated for the small cell carcinoma diagnosis and the treatment was correct as currently seen and the treatment would have been essentially the same irrespective as to where the tumor originated. So in that context the specificity of the primary site isn't an issue at
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all.
Q. Have Ms. Henley's treating physicians concluded in anything that you have read or reviewed that Ms. Henley is suffering from a small cell carcinoma of the lung?
A. Yes. You asked me that question and the answer is yes, that is what they concluded.
Q. Okay. So now I think I may have defined the elements of the dispute. Would you agree that Ms. Henley's treating physicians believe her condition to be a small cell carcinoma of the lung and that you concluded to be a small cell carcinoma of the mediastinum?
A. That is correct.
Q. Okay. With respect to that dispute as now defined, do you see anywhere in the medical records where a physician concluded the diagnosis of small cell carcinoma of the mediastinum?
A. No.
Q. I think in the course of an answer that you were just giving me you indicated that, if I understood it correctly, irrespective of whether this is a small cell carcinoma of the lung or of the mediastinum that the treatment she has undergone would be identical?
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A. That is correct.
Q. What prognosis do you have for Ms. Henley based on her having a small cell carcinoma of either the mediastinum or the lung, though I understand you to have stated that you believe it to be one versus the other?
A. The prognosis in both instances would be poor. There is some evidence to suggest that those originating outside of the lung although eventually fatal may respond to treatment somewhat better than those primary in the lung.
Q. And how would you define better response?
A. If you considered that the average survival of -- and now I am reverting to your hypothesis, if this were a carcinoma of the lung metastasizing to the mediastinum, then she would have had already metastasis, right?
Q. You are asking me a question. I'm not the deponent.
A. You are asking me about the prognosis of the case. The question is that if and the difference between the two, if she were to have or if she had a primary in the lung, then what we are seeing in the mediastinum is metastasis, right, so that is a more advanced stage than just if it were a
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primary in the lung. So with metastasis, a large metastasis, 6cms metastasis in the mediastinum, her prognosis would average -- after treatment would

average a few months.
Whereas, in as we have seen primary thymic tumors, neuroendocrine carcinomas and here I have to say neuroendocrine because there are other carcinomas in the thymus that are not neuroendocrine and those primary in the lymph nodes, although they also are eventually fatal, they do somewhat better and survival for a couple of years and even more has been recorded.
Q. There are some people who receive treatment for small cell carcinoma of the lung who survive two years or more, correct?
A. Generally those are in the absence of large mediastinal metastasis and we come to the fine-tuning of the diagnosis. I am not sure that all the cases that are often published in statistical analysis of neuroendocrine carcinoma of the lung small cell type may in fact be such.
Q. I'd ask you if you would agree or disagree with the following statement: "Small cell neuroendocrine carcinoma is rarely seen in a lifetime nonsmoker."

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A. That statement is out of context. I cannot possibly agree because there are all kinds of small cell neuroendocrine carcinomas in different sites that have never been associated with smoking.
Q. Let's ask it again, then, sir.
With respect to small cell neuroendocrine carcinomas of the lung, would you agree that they are rarely seen in a lifetime nonsmoker?
A. I can only tell you that I have seen them in nonsmokers and that for the most part we do not have records -- we do not keep records in pathology to that effect but on the other hand that is what the literature frequently states.
Q. And I am asking you if you agree with that statement?
A. May I see the piece for which you extracted?
Q. It's my notes, sir.
A. Oh, it's your notes.
Q. Yes. I'm asking you if you agree or disagree with that statement?
A. All I can do is would be what I just told you that I have seen primary neuroendocrine carcinomas of the lung in nonsmokers and the disease, of course, was known to exist before

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cigarette smoking became prevalent so it clearly does exist.
Q. My question to you is, if you agree or disagree with the statement that small cell carcinomas of the lung are rarely seen in the lifetime of a nonsmoker?
A. As I said, that is the statement that the literature generally states, yes.
Q. And have you ever stated that, sir, in any literature?
A. Have I ever stated that in the literature, no, but I recall a paper in which we attempted to differentiate between small cell neuroendocrine -- well-differentiated neuroendocrine

carcinoma in which smoking histories were in fact included.
Q. And in the paper that you are referring to did you conclude that you rarely saw a small cell neuroendocrine carcinoma in a nonsmoker?
A. In that paper that was correct. It was a small series of patients and the majority were in fact or had been in fact smokers, yes.
Q. And would you agree, sir, that small cell neuroendocrine carcinomas are unusual in the next smoker of 15 years or longer?

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A. That is again generally what the literature states, yes.
Q. And have you ever stated that or seen that in populations that you have started?
MR. BARRON: Hold on. Objection. Compound.
MS. CHABER: Fine.
Q. Have you ever stated that, sir?
A. I think that in that very paper that I just mentioned to you some of our patients were in fact ex-smokers and I do not recall the exact definition that we gave for ex-smoker as to the number of years but I do remember that we included a definition.
Q. And did you conclude whatever the number of years for the ex-smoker that it was unusual to find a small cell carcinoma in an ex-smoker?
A. I think that that is true.
Q. Can you tell me pathologically what the staining -- let me go back. You did note immunohistochemical stains of your own in this case, correct?
A. That's correct, I did not.
Q. Are there morphologic characteristics that distinguish or differentiate between a small

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cell carcinoma of the lung in one of the mediastinum?
A. Not to my knowledge.
Q. Are there clinical features which are characteristic of one versus the other? And, again, we are talking small cell carcinomas of the lung versus the mediastinum.
A. Well, characteristically in the case of pulmonary primary you expect to see either an endobronchial and/or x-ray evidence of the presence of a tumor in the lung tissue.
Q. Now, assuming someone has a small cell carcinoma of the mediastinum, how would that create cough in that individual?
A. I have no notion as to why it would or even if it could. One possibility never the less is that tumors of the mediastinum may involve nerves and cause a cough by reflex and/or may compress bronchi and that will give rise to a reflective cough as well and/or the cough may be a manifestation of another problem and the two may be occurring at the same time without necessarily implying cause and effect.
Q. The cough that you have described either by reflex due to compression on a nerve or

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compression on bronchi, would those tend to be dry or sputum-related coughs?
A. It depends on what other problems that would be in the lung.
Q. I'm eliminating that. Assuming there is a small cell carcinoma of the mediastinum and no other condition of infection or something along those lines, would the cough that you've described that would be due to the mediastinal carcinoma either compressing a nerve or compressing bronchi and creating a reflexive cough, would that cough tend to be a dry cough or a sputum, a wet cough?
A. The answer is a little bit complicated if you bear with me. Initially it would probably be dry but inevitably whenever there is compression and/or other compromise of the normal bronchial motility there is increase brownness to infection and, therefore, the cough will become productive. As I said, an additional possibility is that the two phenomena may not be related.
Q. And do people who have small cell carcinomas of the mediastinum generally present with hemoptysis?
A. I have seen a couple of cases that did, yes.

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Q. And how many cases of small cell carcinoma of the mediastinum have you seen in total?
A. If you put those -- those originating in lymph nodes, I would say in the vicinity of 10 or 12. Those originating in the thymus or thymic remnants of it, those I have seen probably in the range of 40 to 50.
Q. The diagnosis that you've given Ms. Henley is that originating in the thymus or in the lymph node?
MR. BARRON: I'm going to object. Lack of foundation that he has selected either.
MS. CHABER: Well, he can tell me that.
MR. BARRON: That's why I made my foundational objection.
MS. CHABER: The question's pending.
THE WITNESS: Would you please repeat it?
MS. CHABER: Could you read it back, please?
(Record read)
THE WITNESS: I cannot be certain since the sample of the tissue was so minute and did not allow me to recognize with certainty either one.
MS. CHABER: Q. When you say with certainty, do you mean with reasonable medical

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probability?
A. No. I mean, I did not see either thymus or a lymph node. All I know is that the mass such as is described clinically and radiologically and by computerized tomography is present inside both lymph nodes and thymic remnants exist.
Q. Do you have an opinion to a reasonable degree of medical certainty which is the more likely site of origin in Ms. Henley, the thymus or the lymph node?

MR. BARRON: Objection. The question is vague and ambiguous. If you are asking for the more likely between those two sites only without regard to any other way in which it becomes in the mediastinum, in other words, you are talking about a mediastinal primary and the question of whether you are talking about mediastinal, not necessarily primary.

MS. CHABER: Q. Doctor, you are talking about a mediastinal primary with respect to Ms. Henley; are you not?

A. That's what I thought that we were talking about.

Q. That's what I thought also.

MR. BARRON: I just want to make sure

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that the record's clear so we don't just --

MS. CHABER: I'll go on and try to clear this up, Counsel.

Q. And the types of mediastinal primaries that you've described for me so far are thymic and lymph, correct?

A. Lymph nodes; that is correct.

Q. Are there other ones that you consider to be a possibility or probability in Ms. Henley's case?

A. The third possibility which is remote. It would not be a primary; but, again, a metastasis from yet another site that has remained silent and undiscovered but that is not a primary in the first place.

Q. And what you have just described as remote that is being a metastasis one of the other sites of metastasis would be the lung; would you agree?

A. The lung would be; but, again, considering all the studies that have been focused on that and the absence of evidence to the effect that in fact she did have a pulmonary tumor leads me away from it.

Q. So we established, then, that of the

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primary tumors in the mediastinum which is what your opinion is in this case; and, again, we are restricting it to small cell neuroendocrine because as I think we've agreed there is no disagreement on that cell type, correct?

MR. BARRON: Hold on. Just a minute.

MS. CHABER: I'm not finished with my question.

MR. BARRON: I thought you were. You don't have to raise your voice. I did think you were finished. If you're not, I will certainly be happy to let you finish.

MS. CHABER: Q. Is it your testimony, Doctor, that there are two primary sites within the mediastinum that the primary tumor of the small cell neuroendocrine type that you believe exists in this case would arise from?

MR. BARRON: Please hold your answer. I'm going to object to the question. The question is now in my view almost unintelligible. It's so compound. It also contains some predicates to which

he has not agreed to talk about, quote, his opinion as if he's rendered one overall opinion that you are alluding to which is not clear and in other ways as I said the question is compound which makes it unintelligible.

MS. CHABER: Q. Doctor, you can answer, if you understood.

A. I confess that I cannot quite understand your question. Let me rephrase what I stated before.

MR. BARRON: Why don't you just let her rephrase the question.

MS. CHABER: Q. Doctor, is it your opinion that Ms. Henley has a small cell neuroendocrine carcinoma that is primary from the mediastinum?

A. Yes.

Q. And is it your opinion further that there are two places within the mediastinum from which primary tumors would originate of the small cell variety that being the thymus or remnants of lymph nodes?

A. No, lymph nodes or remnants of thymus.

Q. Is it your opinion, sir -- now, I'm going to have to go back.

MS. CHABER: Can you read the long question that got objected to that the doctor didn't understand?

(Record read)

MS. CHABER: Q. As between those two sites, Doctor, that we've just talked about, the lymph nodes or remnants of the thymus for a primary small cell carcinoma of the mediastinum, do you have an opinion to a reasonable degree of medical certainty which is more probable in Ms. Henley's case?

A. No, I do not.

MR. BARRON: Hold on. I have to make the objection. I don't understand the phraseology probability and the medical certainty. I think it's almost an oxymoron.

MS. CHABER: They are identical, Counsel, in the California definition.

MR. BARRON: I don't know that so we will see what the case is.

MS. CHABER: I believe you gave an answer, Doctor.

Q. Had you completed your answer?

A. Would you repeat now what I said because I wasn't finished with my reply.

Q. I didn't think you were when counsel interrupted.

A. Can you read my reply back?

Q. We may be here longer than I anticipated.

(Record read)

THE WITNESS: No, I do not have an opinion. I believe it would be literally impossible to render an opinion without having the whole specimen. And even if you did, the tumor may have obliterated by now any identifiable remnants of

thymus and/or lymph nodes; on the other hand, it may not but we do not have the whole specimen.

MS. CHABER: Q. And is there a way on a pathologic basis to differentiate between this being a metastatic to the mediastinum versus a primary to the mediastinum or primary from the mediastinum?

A. It depends on what metastases you're talking about. In the case of some metastatic sites it may be possible. In the case of the thymus versus lymph nodes, it is not and in the case of the lung versus thymus versus lymph nodes it is not.

But at the same time the pathologic opinion is not based exclusively on the study of slides. We work normally, all pathologists do, with clinicians and we listen to what they find grossly and/or after surgical exploration and, of course, by x-ray.

Q. You indicated that there were certain immunostaining that had either positivity or

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negativity that was part of your opinion as to why this is a primary from the mediastinum, correct?

MR. BARRON: You're misstating his testimony.

THE WITNESS: No, ma'am, I did not. I did not state such thing. My statement was that the cytokeratin and synaptophysin positivity and the negativity for the CD45 and chromogranin I believe established the diagnosis of small cell neuroendocrine carcinoma, period.

MS. CHABER: Q. If this was in Ms. Henley's case a primary from the lung, is it your opinion that the immunostaining that you just identified, the cytokeratin, CD45 chromogranin and synaptophysin would demonstrate the same positivity and negativity as described?

A. As stated they would be indistinguishable.

Q. And that's because those tests are used to determine cell type and not cell origin?

A. That is correct.

Q. Are you aware of any immunostaining that can be done to determine site of origin?

A. As I said, if you limit your differential diagnosis to those that we are talking about today,

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namely, lung versus thymus versus lymph node, the answer is no. There are a group of occasional small cell neuroendocrine carcinomas occurring in the skin, for instance, that do have a certain cytokeratin, cytokeratin 20 that is not present in the others, but that would be --

Q. But if we limit it to what we are talking about here --

A. The answer would be indistinguishable.

Q. And there are no tests that you are aware of that would enable a pathologist to make a further differentiation if we are talking about the differentials that we are talking about here?

A. Not to my knowledge, ma'am.

Q. Would electronmicroscopy add any information on the differentials?

A. Not to my knowledge. The findings would

be identical.
Q. Would there be any hormonal type of testing of any materials that would contribute to determining which of the differentials is correct?
A. Again, not to my knowledge. Both or, in fact, the tumors of the thymus and of the lung a small minority of them are associated with an abnormal hormone production and it so happens that

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they are the same.
Q. Do you have a prognosis as to Ms. Henley's life expectancy?
A. I would not be able to issue a prognosis. She had a tumor limited to the mediastinum but was treated and to my knowledge he has responded well and is doing well but what now nine months or so after treatment; is she doing well? I don't know that for a fact. If she is, she's already beating the average if it were from the lung.
Q. Based on all the information that you have in Ms. Henley's case, can you give us your opinion as to how long Ms. Henley has in terms of life expectancy?
A. No, I would not be able to tell you that, but I can tell you that I have seen tumors both of the thymus and the mediastinum that were treated approximately in this manner that survive beyond two, three and four years.
Q. Will Ms. Henley be able to be cured of her cancer, this cancer?
A. I don't know. It depends a little bit again on what you mean by cured. But as I said, she has received the current conventionally accepted treatment. She has responded well and she is

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already beating the odds. But whether she will be with us ten years from now, I wouldn't bet.
Q. You wouldn't bet that she would --
A. No, I would not bet that she would. I don't know but I have seen a number of cases survive for several years.
Q. Ms. Henley is 52 years old. Assuming no other illnesses other than what we are talking about now, will Ms. Henley live her normal life expectancy based on this diagnosis?
A. I cannot really give you a rational reply that would be anything beyond what you've told me not to do, namely, which is a guess; but the fact remains that she has had a serious aggressive cancer and let us not forget that she has received very significant and aggressive therapy which itself is associated with diseases in the future.
Q. Do you in the course of your clinical practice ever have to tell patients what you believe to be their prognosis with respect to life expectancy?
A. No, I don't.
Q. And with respect to the disease that it is your opinion Ms. Henley has to a reasonable degree of medical certainty, can you state what her

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range of life expectancy is?
A. No, I would not be able to.

Q. Would it be unusual for her given that diagnosis to still be living ten years from now?
A. I have seen at least one case that did but the majority did develop metastases in between periods. Nevertheless, they have done consistently better than those with a lung primary.
Q. Are mediastinal small cell carcinomas what is the most likely site of metastasis from there?
A. They vary. They give, of course, pulmonary, liver, brain, bone metastasis, the classical pattern of a small cell carcinoma of all sites, in essence.
Q. And is it more likely that a mediastinal small cell will metastasize to the lung than, say, to the liver?
A. They at times do peculiar things and they do what is called jumping organs and inexplicably they will do certain things. I think that the relative -- in terms of relative frequency the metastasis is other lymph nodes, lung, liver, bone and brain or brain and bone.
Q. How many small cell lung carcinomas have

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you seen in your professional experience?
A. Many hundreds.
Q. In terms of relative frequency, can you give me the relative frequency of small cell lung carci -- excuse me, of small cell neuroendocrine carcinomas with respect to a site; that is, I'm asking for the frequency that a primary is in the various sites?
A. In the various sites so lung would be No. 1; the gastrointestinal tract would be No. 2, and within it the colon would be No. 1 the stomach would be No. 2.
Then the third is probably the skin and then you have lots of miscellaneous sites in which they do occur sporadically that include the cervix of the uterus, the salivary glands, the gallbladder, the pancreas, of course, and the thymus, lymph nodes and things of that sort.
Q. With respect to the total number of small cell neuroendocrine carcinomas, can you give me a percentage -- now that we have the frequency can you give me a percentage that are primaries of the lung?
A. No, I cannot. I have never really looked and I don't know of any particular literature that look that way. Moreover, it would vary whether you

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are dealing with surgical biopsies or autopsy material.
Q. Do you know of anyplace where that information could be determined?
A. At the moment I have no idea.
Q. Do you know how many small cell lung carcinomas are diagnosed in any given year in the United States?
A. No, I only know those that I see; and, again, small cell neuroendocrine carcinoma as they are informed in the overall statistics may not, may not fall within the strict definition of what I call small cell neuroendocrine carcinoma because there

are others that are neuroendocrine carcinoma but they are not small celled. I'm sorry if this is confusing.

Q. I'm trying to limit my questions to small cell neuroendocrine carcinomas and with that in mind is there anyplace where that information is kept, that is, the total number of diagnoses or deaths if that's kept anywhere of lung small cell carcinomas?

A. I will try to explain to you the reason as to why I cannot give you a precise answer. The fact is that often the vital statistics published by various organisms lump together a variety of

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neuroendocrine carcinomas that are generically called small cell, although they may include and in fact they do include other variants that are not small cell. Whereas we and other groups are much stricter in the definition of small cell for the simple reason that it is associated with a much worse prognosis than the others.

Q. Are you aware of any publication group that you would consider authoritative on the number of small cell carcinomas diagnosed in any given year?

A. I don't know.

Q. Do small cell carcinomas of the lung get reported in the SEER data, S-E-E-R?

A. I'm sure they are; but, again, the problem is as to what is called and what is defined as small cell carcinoma and those definitions are not as widespread and uniformly applied.

Q. I understand that you are saying that there might be a small cell carcinoma reported that you might not agree was a small cell carcinoma. However, my question is, is that information whether you agree that those are all small cells within that information provided by any publication, authority, textbook, group, to your knowledge?

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A. I don't follow that side of the literature at all.

Q. You've given me the relative frequency of various sites to small cell carcinomas. Can you give me --

A. As I see it in our practice.

Q. So your frequency was solely limited to your own practice?

A. I would say that for the most part it would probably reflect what hospital practice would in fact entail; but, remember, that we are in a day in which very few autopsies are being performed and very few autopsies.

And so I would not be one bit surprised if neuroendocrine carcinomas of other sites are being missed. And as you know, this is a problem that is reaching national proportions and it has reached the TV news and dedicated an entire issue of a Journal of the American Medical Association and so on. So, in other words, a number of statistical data that are derived from very limited sampling off surgical material only may in fact be misleading.

Q. Do you believe that the frequency that you've cited of your hospital practice, do you have

any reason to believe that it is not characteristic
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of the national data?
A. No, I would say that it is in fact probably quite reflective of the hospital practice for which most of those statistics are derived, but I attempted to outline for you some of the pitfalls that are in it.
Q. Do you believe cigarette smoking causes any disease?
A. Again, causation has not been the focus of my work.
Q. Do you have opinions with respect to whether or not cigarette smoking can cause disease?
A. No, I do not.
Q. Do you have opinions that cigarette smoking does not cause disease?
A. No, I do not.
Q. When is the first time, sir, that you were ever contacted by anyone involved with a cigarette manufacturer?
A. If I remember correctly, in 1985 maybe, '84, '85, '86, thereabouts.
Q. And was that in connection with a specific case or was that a generalized contact initially?
A. No, it was in connection with a specific
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case.
Q. And that would be the Chippolone case?
A. That is correct.
Q. Let me ask you this: With respect to the payments I assume with respect to legal cases, I assume the attorneys for Philip Morris are paying you for the time spent consulting with them?
A. That is correct.
Q. And how much do you charge for that time?
A. 500 an hour.
Q. And how many hours to date excluding the time when we started this deposition have you put in in this case?
A. I cannot recall exactly but it's probably under ten, somewhere in that vicinity.
Q. And do you plan on billing or have you already billed the attorneys?
A. I have.
Q. Okay. And how much have you been paid to date?
A. That I don't recall. I don't recall how much I have been paid to date. But as I said, it should be in that vicinity.
Q. And do you anticipate doing additional work on this case?
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A. I have no idea what the outcome of this case will be or how it will evolve.
Q. In terms of the opinions that you presently have expressed, do you believe that there is any additional work you need to do?
A. At this moment I cannot think of any.
Q. Have you agreed to testify at trial on this case?
A. If it comes to that.

Q. Have you been advised as to what the trial date is?
A. No.
Q. Are you planning to be out of the country for any extended period of time in the month of January?
A. In the month of January I will be on duty the entire month so I will not be outside the country.
Q. And when you say on duty, what is the schedule that you would keep?
A. That I have to be available at all times.
Q. And would that mean that you would be precluded from making an appearance in court if you were asked to do so in California in January?
A. It would have to include the caveat to

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that that I would have to get coverage from one of my colleagues; so if it is possible, of course, I will do it.
Q. And what does that involve for you to get coverage from one of your colleagues?
A. Asking someone who at that moment happens not to be on duty as well as I am and happens not to teach since we are in the middle of the semester, we will be in January, that is, and so on and so forth. It depends. We are a relatively small department so it's not -- I don't have a great deal of elbowroom; is that clear?
Q. It was to me.
Other than the payment for your time in consultation in this case, are you aware of any contributions to your medical college or to your hospital center by anyone representing a tobacco company?
A. Not to my knowledge.
Q. In terms of the payments for your consultations in a legal case such as this, do those payments go to you or are those payments that you then must turn over to the university or the hospital?
A. I consistently put a proportion of that

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which varies. It depends on -- I will always put the proportion on the research funds of the institution.
Q. And in this case of the moneys you have been paid to date, have you put any portion of that to the institution?
A. The year has not finished so eventually I will.
Q. And do you know of the money paid to date what percentage of that you intend to put to the research funds?
A. Probably at least a third.
Q. And those research funds are funds that fund your research, correct?
A. No. They fund the thoracic research in which other people work, not just me.
MS. CHABER: It's five to 1:00. Let's go off the record for a second.
(Off the record)
(Break 1:01 p.m. to 1:15 p.m.)

MS. CHABER: Q. Doctor, I thought I had asked you this question but I cannot find this in my notes, so if you would bear with me when I ask you what may be a repetitive question: What would be the mechanism of a mediastinal small cell carcinoma causing hemoptysis?

A. I'm not sure as to what the mechanism was or would be and one of them would be bronchial compression and the other possibility, as I said, would be the two phenomena may not be related. Hemoptysis is an extremely frequent phenomenon in people who cough for a variety of reasons.

Q. With respect to Ms. Henley's case when she presented in December of 1997, she presented with a productive cough in hemoptysis; what in your opinion accounts for the hemoptysis that she presented with?

MR. BARRON: May I have that question reread?

(Record read)

THE WITNESS: As I said, I'm not sure what the mechanism would have been. The tumor in the mediastinum was present then. In addition, she was thought to have an infection. In fact, she was treated with antibiotics and she responded well, so the question or the cause of the hemoptysis remains unclear.

MS. CHABER: Q. Can you cite me to the medical record that indicates that she responded well to the treatment with antibiotics?

A. Well, she sees one for a while whatever the symptoms were. She was considered to have pneumonia and she responded.

Q. Do mediastinal small cell carcinomas generally present with hemoptysis?

A. When you say generally, we are talking about very uncommon tumors and have I seen them presenting with hemoptysis and I already answered you that question and the answer is yes, yes, I have.

Q. On how many occasions have you seen a mediastinal small cell carcinoma present with hemoptysis?

A. I can recall several.

Q. When you say several, can you give me an idea what you mean? Different people have different meanings.

A. Three or four. We are talking again and I repeat an uncommon condition.

Q. And with respect to lung carcinomas and again we are talking about small cells, would you agree that hemoptysis is one of the primary presenting symptoms?

A. It is not one of the more frequent symptoms. It is in the list but it's by no means on top of it.

Q. What's on top of the list for the presentation of a lung small cell carcinoma?

A. Cough and systemic signs and symptoms.

Q. What kind of systemic signs and symptoms?

A. Severe weight loss, severe lost of appetite, there could be fever, anemia.
Q. What percentage of small cell lung carcinomas present with hemoptysis?
A. I couldn't tell you; but as I said, it is definitely not on top of the list.
Q. Where within the list is it in terms of --
A. Somewhere -- I would say somewhere around midway probably.
Q. When you say cough, is that generally a productive cough or dry cough?
A. It depends on what associated conditions there may be. People who present with a large as in this case would be the case if it were in a tumor are often very ill, systemically ill.
Q. And what does that relate to whether the cough is dry or productive?
A. Oh, that they are often -- as I said, they may be anemic and they are prone to common

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infections.
Q. Do people who present with mediastinal carcinomas such as Ms. Henley did in your opinion generally present with a productive cough and hemoptysis?
A. I repeat when you say generally, I have seen several instances in which they presented exactly with those symptoms.
Q. And that would be the three to four that you talked about?
A. Yes.
Q. And I think you said you saw hundreds -- and I don't want to misquote you so please correct me if I'm incorrect -- many hundreds, is what I wrote down, of lung small cell carcinomas?
A. Yes, what about them?
Q. Can you give me an idea what you mean by many hundreds?
A. Well --
Q. 100, 200, 900?
A. If I would say roughly estimate at the range of 75 to 100 per year that I have seen only since I have been at Rush so you have something like 2,500, some of our -- most of our cases would be ours. Many would be patients that come to us for

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treatment or for confirmation or with metastasis and so there's a whole range of presentation.
Q. And you've been at Rush since when?
A. 1975 so that's why I said roughly a couple of thousand.
Q. And before that? I haven't gone specifically into your CV.
A. I probably saw several hundreds and moreover as the early status of my career when autopsies were much more frequent, remember that we saw many autopsy cases as well that may or may not have been treated at our hospital.
Q. And since you have been at Rush since approximately 1975, how many mediastinal small cell carcinomas have you seen per year?
A. If you will refer to those of the thymus

in which there is a surgical specimen as distinct from a small biopsy, we'd probably see in the range of a couple a year.

Q. That would be two to three, two?

A. I would say in that range. Now, when you are talking about those that originate in lymph nodes, that is a relatively recent idea going back to the late '80s and '90s and so we have not looked.

It would be probably impossible to look

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at the records to find out if there were other cases that were incorrectly assumed to be metastatic when in fact they were primary. So starting from roughly 1988, '89, as I said, we have seen somewhere in the vicinity of 10 or 12.

Q. Total?

A. Yes.

Q. Not per year; you are talking total?

A. No, total. And I have seen a number of cases from the outside that were not ours and there have been at least two publications that I know of of other people that have seen the same thing.

Q. Can you cite me to those publications?

A. Well, one of them is in the American Journal of Surgical Pathology of 1992 and the senior author is I believe a fellow by the name Eusebi, E-u-s-e-b-i first initial V from Vincent. Okay. I believe it was in 1992.

And then there is at least another paper in a journal published in Spanish called Pathologia; and, of course, our own publications and a number of cases we have seen since that have not been published.

Q. The two publications that you cited to would be cases reported separate from the 10 to 12

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total or including those?

A. They would be separate.

Q. Do you know the author of the article, of the Spanish article?

A. I don't remember who the senior author was, but I do remember and in fact know one of the authors who was not the senior author and the name is Elsner, E-l-s-n-e-r, first initial B, like in boy. In fact, I was asked to write an editorial about that paper in the journal which I did.

Q. In the same journal?

A. In the same journal, in the same issue.

Q. And what year is that?

A. I believe '95 if my memory serves me correctly.

Q. It would be reflected -- your editorial, that is, would be reflected in the publications on your CV?

A. It should be, ma'am.

MR. BARRON: Did you want him to take the time to find it?

MS. CHABER: You can do it quickly and then I can take a bite of my turkey.

THE WITNESS: Yes, I do have the reference and it was '95.

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MS. CHABER: Q. And what number is it on

your CV?
A. No. 200.
Q. Thank you. Have you read or reviewed Dr. Hammar's deposition?
A. No, I have not.
Q. You have reviewed Dr. Hammar's report, I believe you stated?
A. Yes, I have.
Q. And other than his conclusion that this is a small cell carcinoma of the lung, were there other disagreements you had with Dr. Hammar?
A. If you allow me to take a quick look at that.
Q. Do you want to take a look at my copy because it's all marked up from me?
A. It's in there. You have appropriated my copy.
Q. Of that, yes.
A. No.
Q. Of Dr. Hammar's?
A. It was within those two clamps.
Q. Well, then it would still be there because I didn't -- this is a copy that came out somewhere else?

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A. It was him.
Q. Yes, I may have appropriated but not marked up.
A. Yes, my disagreement with Dr. Hammar is as you realize I concur entirely on the fact that this is a small cell carcinoma. What I do not agree is that it was a primary in the lung and I have no opinion, I neither agree nor disagree with the fact that it was or may not have been caused by cigarette smoke as he states on No. 13.
Q. Where is the hilum?
A. The hilum is the area of the lung or any other organ in which the vital vessels end or structures that drain into or outside of it enter or leave and/or leave the organ.
Q. Is the hilum of the lung a part of the lung or is it a separate --
A. The hilum of the lung is a virtual space if you know what I talk about. It is not something that you can grasp in your hand as you can a vessel or a bronchus.
Q. Is it considered a part of the lung as opposed to a separate organism?
A. No, it is not part of the lung.
Q. Is it part of the mediastinum?

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A. It is in the mediastinum; that's correct. As the hilum of the kidney would be part of the retroperitoneum.
Q. Is a hilar mass considered to be a diagnosis of a mediastinal mass?
A. Very often the term clinically is used a little bit loosely, ma'am, and a mass may be in the hilum, may be in the mediastinum, and may also involve the organ itself, if you know what I mean.
But generally when they say hilar, they refer to something that is outside of the organ such if it were within the organ whichever it may be,

then they would say intraparenchymal or intrapulmonary or within it or within that.
Q. Would you agree that small cell lung carcinomas typically present in the hilar region?
A. The majority of them occur in main bronchi which is a different story from presenting in the hilar region.
Q. Do some proportion of small cell lung carcinomas present in the hilar region?
A. As I said, when you say in the hilar region, the implication is in the space that we are talking about, but the majority of small cell neuroendocrine carcinomas are presenting and

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diagnosable as endobronchial lesions; in other words, you will find something in the bronchus. It may be in part of the bronchus that's slightly outside the lung or inside or both, but it will be within the bronchus. There was not such a thing in this case.
Q. Are there small cell lung carcinomas that do not present as endobronchial lesions but rather that present in the hilum?
MR. BARRON: I'm going to object to the form of the question as ambiguous when you use the word, quote, present, closed quote, in the type of sentence you are now creating.
MS. CHABER: Q. You can answer.
A. The answer is that small cell and all other carcinomas of the lung either present within the bronchus or within the bronchi or more distal into the parenchyma. They will not present as a mass in the mediastinum without compromise of a bronchial mucosa.
Q. Are there small cell carcinomas of the lung that present in the hilum?
A. They will. If they present in the hilum, then they are in the hilum which is that virtual space. They present as endobronchial lesions. They

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occur. They start by definition a mucosa of the bronchus.
Q. And they can inevitably be seen on bronchoscopy?
A. The majority of them are diagnosed by biopsy, by endobronchial biopsy and/or cytology. There is a small percentage that occur more peripherally in the lung that cannot be reached by the conventional bronchoscope; but, again, in that case you have an intrapulmonary mass or an intrapulmonary nodule that is detectable by x-ray techniques of various types.
Q. In the majority of cases in which the patient presents with a small cell carcinoma of the lung, can you identify that tumor using a bronchoscopy?
A. The majority are, yes, and biopsy and then diagnosed accordingly.
Q. So in your opinion you usually see an exophytic lesion?
A. Exophytic, of course. The surgeon will see either an exophytic, namely, something that sticks out from the normal lining and/or an ulcer or

both and he will be -- that's exactly what he would do by a biopsy and most of the time he will either

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brush it and/or lavage it and obtain a psychologic specimen as well.

Q. Can you cite me to any articles or any literature that discuss the frequency with which small cell carcinoma of the lung on bronchoscopy present with an exophytic lesion?

A. No, I cannot but I can tell you that it's something that occurs every day.

Q. Would you agree that small cell carcinoma of the lung generally grow outward rather than inward into the lung parenchymal?

A. They will do both and then they will invade vessels and/or lymphatics and metastasize at a distance.

Q. Do you believe that one is more common than the other, that is, outward growth versus inward growth on lung carcinomas small cell?

A. I think that both occur. Obviously the exophytic growth is limited by the diameter of the bronchus. In other words, it cannot grow beyond obstructing the bronchus so there will be more growth towards the outside because that's the only place that it has to go, if you follow me.

Q. Now, you indicated that there were certain radiologic findings that you felt were

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diagnostic of this being a mediastinal primary; is that correct?

A. No, I didn't say exactly that but what I said is that the reports consistently speak of the mediastinal mass. At no time do they speak of the pulmonary mass.

Q. Do any of the reports speak of a hilar mass?

A. Yes, they do, but they are using the words synonymously with mediastinum, in other words, outside the lung. If it were within the lung, they would use the word intrapulmonary nodule or mass.

Q. So in your opinion the use by the treating physicians in this case of the language hilar mass is indicative of their saying that this is in the mediastinum versus the lung?

MR. BARRON: Objection. That question is compound as to the word the treating physicians being more than one. Vague and ambiguous.

MS. CHABER: Q. You can answer.

A. Be that as it may. The fact is that the tumor was outside the lung. That no diagnostic material of any kind was obtained from within it and that the only diagnostic material that was in fact obtained which is diagnostic was obtained from the

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mediastinum.

Q. My question to you is a little bit different. You indicated that you did see the language in the medical records that were provided to you of the words hilar mass having been found, correct?

A. The word that is used, yes.

Q. And I'm just asking you if in your

opinion when that is used, those doctors are meaning mediastinum?
A. I have no idea what they mean, but what I do know is that the mass is in the mediastinum, and that no mass or no lesion was found within the lung.
Q. Can a mass be considered a hilar mass and be impacting or compressing on the mediastinum without being a mediastinal primary?
MR. BARRON: Can I have that reread, please?
(Record read)
THE WITNESS: I am sorry. The question is not intelligible as I see it. If I can again state what I think that may be the issue is the mass is outside the lung and part of it is clearly quite a bit away. We are talking about something that is 6cms in diameter and some of it is in the area of

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the hilus indeed. It is hugging the main branch of the pulmonary artery that is stated many times but the issue remains that there is no mass within the lung.
MS. CHABER: Q. Are parts of the respiratory tract within the mediastinum?
A. Of course. The trachea is within the mediastinum and the division of the trachea into the two main bronchi in the mediastinum before they enter the lung.
Q. Would you agree that the following findings are typically found in a small cell lung carcinoma? And I'll ask you them one at a time.
MR. BARRON: Before you do that, I'd like you to clarify the word, quote, typically, closed quote, if you would; otherwise, it is ambiguous.
MS. CHABER: Q. Do you believe that there are typical presentations of small cell lung carcinomas?
A. We have discussed that issue a few minutes ago.
Q. How do you define typical presentations? He's objecting. So I'm entitled to find out what your definition of it is so that we are having the same discussion. That may be amusing but it is

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proper.
A. Typical is something frequent or common as this thing from atypical which would be infrequent and relatively uncommon.
Q. Based on that --
A. Now, I wasn't finished. Now, in terms of pathology, the word typical and atypical is used in a different context. A typical cell is one that either is or resembles a normal cell and atypical cell is one that can still be recognized as coming from A, B or C, D side but have features which are not normal to the counterparts, so I just wanted to finish that.
Q. The radiologic studies that were done do you believe that they indicated obstruction of the left main pulmonary artery?
A. That's what they state.
Q. And do you believe that obstruction of the left main pulmonary artery is a more frequent

finding in a small cell lung carcinoma than in a mediastinal lung carcinoma?
A. It is an infrequent finding at presentation of a small cell lung carcinoma as distinct from the terminal faces of it; whereas we have seen several of the primary carcinomas of lymph

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nodes presenting hugging main vessels and bronchi indeed, presenting as distinct from being a terminal phenomena.
Q. Do you believe that there was any involvement of the tumor with the left main stem bronchus?
A. It was clearly in the vicinity of it but it was outside of it.
Q. And what are the basis of your saying that it was outside of it?
A. The fact that the endoscopist does not -- specifically notes that the mucosa does not show any lesions. In fact, if there had been a lesion or anything in the least suspicious, he would have a biopsy and/or brushed it and/or lavaged it and that wasn't the case.
Q. Is the absence of a bronchial alveolar lavage in your mind indicative of the -- a conclusion by the endoscopist --
A. Endoscopist.
Q. -- endoscopist that this was not a lung carcinoma but rather a mediastinum?
A. I don't know what he concluded but I am certain that he did not lavage it because he didn't see what to lavage.

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Q. Now, you had tabbed certain reports first in the --
A. Yes, I have.
Q. Okay. Can you tell me what -- why you have tabbed the --
A. This is nearly to call my attention to this particular which is the original -- let me give you the pages if you don't mind.
Q. And the page appears at the end of tab No. 1 and it is Bates stamped 00054 Los Angeles County USC Medical Center.
MR. BARRON: While you look at that, may I just alert you that it's a few minutes before 2:00 and --
MS. CHABER: I'm doing the best that I can.
MR. BARRON: I'm not criticizing your work effort. I'm just indicating the time to you and that he really does have to leave at 2:15 to be sure to be able to be processed and get on the plane.
MS. CHABER: I have no problem. If I am not concluded at 2:15, maybe we can continue this for a short time by telephone. I wouldn't obviously make you bring the doctor out again. That would be

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acceptable.
MR. BARRON: Well, let's defer that because it looks like you are coming close to finishing anyway.

THE WITNESS: Let me interject if I may, if you foresee that there is much more that you will wish to ask, then I'd rather prefer to cut now. I will have to brush my teeth and make some phone calls. If you don't mind, if you foresee that has to be done, what's the difference doing half an hour or one hour now if we have to.

MR. BARRON: I think she's almost finished.

MS. CHABER: No, I never said that.

MR. BARRON: You didn't say that. I thought from the way you were addressing the issues that you were about finished. If I'm wrong, I'm wrong.

MS. CHABER: You are wrong because I have a whole other folder of material that I would turn to.

MR. BARRON: Why did we schedule it for roughly two hours and start as late as we did? I came in late to the discussions.

MS. CHABER: I didn't schedule it for

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roughly any number of hours and your office picked the time to begin it so, you know, that's all I'm aware of.

MR. BARRON: So you didn't give a time estimate.

MS. CHABER: Well, I had no report. I had no idea what the doctor's opinion was. I had no way of being able to give a time estimate. I hoped I would be able to do it in three hours or thereabouts but under the circumstances I can't.

I don't think that there is any crime in that and I certainly understand the doctor's position that rather than race to the airport and continue this for another half hour, that we will conclude it in a question or two and we can continue it for 45 minutes or an hour on the telephone.

THE WITNESS: I think that is what's required and that's what it will be.

MS. CHABER: And potentially if I do that, maybe I can get it down to an hour, but I don't think I can finish particularly under the pressure of not wanting to make the doctor late for a leaving time when it's 2:00 o'clock now.

MR. BARRON: Fine. You are being a little too defensive. I wasn't in any way

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criticizing that you might have the need as a plaintiff's lawyer to have two hours, three hours, four hours, six hours. I just heard that the estimate had been given as two hours; and if there's a misunderstanding there, you never said that, you never said that.

I was just curious. I don't know how it got set for 10:00. I just got involved as you know. And if we are going to have the kind of time pressures, I prefer to start at 9:00 or 8:30.

MS. CHABER: So would I. Nobody told me an end time and I was told this is when I should come here. I didn't pick the beginning time nor did I pick his flight schedule; so, you know, I'm not trying to get into any kind of argument with you.

I'm reflective of I don't think I can finish in 15 minutes and I don't want to put the doctor under the pressure of trying to race to a plane when I don't think I can conclude.

MR. BARRON: Let's take a two-minute break. The only reason I bring it up is so you can tell I don't know enough about all the logistics and the scheduling problems we have. I am aware of a January 4 trial date. I know he's going to be out of the country and I am concerned about being able

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to get the appropriate people together even by telephone. I'm not saying it can't be done, but --

MS. CHABER: You may not be able to get all three lawyers from Shook, Hardy, but I'm sure you can find a Shook, Hardy lawyer to -- the doctor seems to do just fine at a deposition.

MR. BARRON: Let's take a two-minute break and let's find out from him.

MS. CHABER: We can go off the record.

(Off the record)

(Break from 2:04 p.m. to 2:14 p.m.)

MS. CHABER: After a fair amount of discussion off the record, I think it was concluded that I was not concluded with Dr. Gould's deposition and that Dr. Gould had an airplane that he wished to make and I have requested a continuation of this and certainly under the circumstances would agree to continue it by telephone so that Dr. Gould would not need to appear again and I certainly would accommodate his schedule as well as try to work something out to accommodate all of our schedules in that regard.

MR. BARRON: And I will just indicate that you should continue to work out those logistic matters with the people with whom you've been

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dealing and let that person respond to whether it makes sense to do what you suggest which it may certainly and then the timing of it because I don't know where he's going to be other than apparently he's out of the country for most of the month. I guess I'll let the people who know his schedule speak to you on that if that's fine.

MS. CHABER: Okay.

(Deposition adjourned at 2:16 p.m.)

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SIGNATURE OF WITNESS